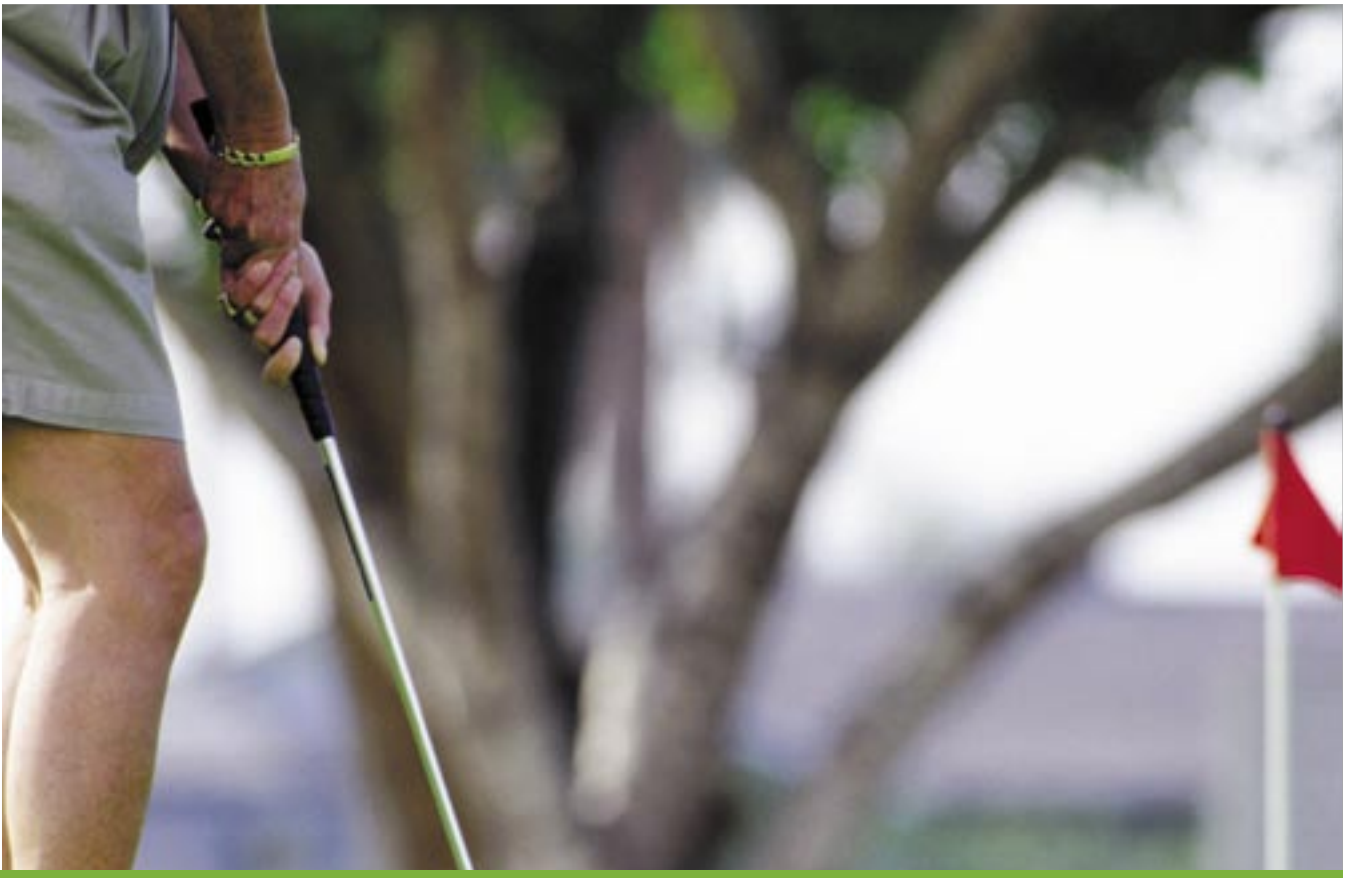
CalPERS

Health Benefit Summary

2006



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Important!

This booklet summarizes benefits offered by CalPERS Health Maintenance Organization (HMO), Exclusive Provider Organization (EPO) and Preferred Provider Organization (PPO) plans. Please refer to the plan's 2006 Evidence of Coverage (EOC) booklet for the exact terms and conditions of coverage. Plans mail EOCs to current members before Open Enrollment and to new members at the beginning of the year, or to any CalPERS member upon request.
In case of a conflict between this summary and your plan's EOC, the EOC booklet determines the benefits that will be provided.

HMO Basic Plans

Blue Shield of California [1], Kaiser Permanente, Western Health Advantage

Note: All footnotes are located on inside back cover.

BENEFITS	Copay and/or Benefit Limits [2]
HOSPITAL	
Inpatient	No charge
Outpatient	
Blue Shield and Western Health Advantage	No charge
Kaiser Permanente	$10/visit
PHYSICIAN SERVICES	
Office Visits *More than one copay may apply during an office visit if multiple services are provided.*	$10/visit
Gynecological Exam	$10/visit
Periodic Health Exam	$10/visit
Well-Baby Care	$10/visit
Allergy Testing/Treatment	
Blue Shield and Western Health Advantage	$10/visit
Kaiser Permanente	$5/visit
Immunization/Inoculation	$10/immunization
Vision Exam (Refraction) *For age 17 and under. Varies by plan for age 18 and over and may be limited to one visit per calendar year.*	$10/visit
Hearing Exam/Screening	$10/visit
Inpatient Hospital Visits	No charge
Surgery/Anesthesia	No charge
DIAGNOSTIC X-RAY/LAB	
Outpatient Services	No charge
PRESCRIPTION DRUGS	
Blue Shield and **Western Health Advantage** Retail Pharmacy *(up to 30-day supply)*	$5/generic $15/formulary brand name $45/non-formulary *($30 if medical necessity approved)*
Mail Order Program *(up to 90-day supply)* *$1,000 maximum copayment per person per calendar year.*	$10/generic $25/formulary brand name $75/non-formulary *($45 if medical necessity approved)*
Kaiser Permanente *Provides up to 100-day supply (or a 30-day supply for certain drugs) through either its pharmacies or mail order program.*	$5/generic $15/brand name

HMO Basic Plans

Blue Shield of California [1], Kaiser Permanente, Western Health Advantage

Note: All footnotes are located on inside back cover.

BENEFITS	Copay and/or Benefit Limits [2]
DURABLE MEDICAL EQUIPMENT	
	No charge
INFERTILITY TESTING/TREATMENT	
Professional, hospital, ambulatory surgery center, ancillary services and drugs administered to diagnose and treat infertility. Excludes in vitro fertilization, ovum transplant, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and reversal of voluntary sterilization.	50% of covered charges
AMBULANCE	
Air/ground ambulance services	No charge
EMERGENCY SERVICES	
Waived if admitted as an inpatient or for observation as an outpatient	$50/visit
MENTAL HEALTH	
Inpatient *No limits for severe mental illness of a child or adult or emotional disturbance of a child.* *Up to 30 days/calendar year for treatment of acute phase of mental health conditions during certified confinement in participating hospital.*	No charge
Outpatient	
Blue Shield and Western Health Advantage	
For severe mental illness of a child or adult or emotional disturbance of a child.	$10/visit *(no visit limits)*
Evaluation, crisis intervention and treatment for other mental health conditions.	$20/visit *(up to 20 visits/calendar year)*
Kaiser Permanente	
For severe mental illness of a child or adult or emotional disturbance of a child.	$10/visit *(no visit limits) individual* $5/visit *(no visit limits) group*
Evaluation, crisis intervention and treatment for other mental health conditions.	$10/visit *(up to 20 visits per calendar year) individual* $5/visit *(up to 20 visits per calendar year) group*
SUBSTANCE ABUSE TREATMENT	
Inpatient *Acute medical detoxification only*	No charge
Outpatient *Evaluation, crisis intervention, and treatment for conditions subject to significant improvement through short-term therapy.*	$10/visit *(up to 20 visits/calendar year)*

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HMO Basic Plans

Blue Shield of California [1], Kaiser Permanente, Western Health Advantage

Note: All footnotes are located on inside back cover.

BENEFITS	Copay and/or Benefit Limits [2]
HOME HEALTH SERVICES	
Custodial care not covered.	No charge
SKILLED NURSING FACILITY CARE	
Medically necessary services provided in licensed skilled nursing facility. Custodial care not covered.	No charge *(up to 100 days/calendar year)*
SPEECH/PHYSICAL/OCCUPATIONAL THERAPY	
Inpatient - hospital or skilled nursing facility	No charge
Outpatient - office and home visits	$10/visit
HOSPICE	
	No charge
ACUPUNCTURE	
Offered by Kaiser Permanente when deemed medically necessary by a physician	$10/visit
CHIROPRACTIC	
Offered by Kaiser Permanente only in California and by Western Health Advantage	$10/visit *(up to 20 visits/calendar year)*
BLOOD & BLOOD PRODUCTS	
	No charge
HEARING AID SERVICES	
Audiological Exam	No charge
Hearing Aids *(Offered by Kaiser Permanente in California only)*	$1,000 maximum *(every 36 months)*

PERS Choice & PERSCare PPO Basic Plans

Note: All footnotes are located on inside back cover.

BENEFITS	PERS Choice		PERSCare	
CALENDAR YEAR DEDUCTIBLE	*(not transferable between plans)*			
	Your Cost		**Your Cost**	
Individual	$500		$500	
Family	$1,000		$1,000	
	PPO	**Non-PPO**	**PPO**	**Non-PPO**
HOSPITAL ADMISSION DEDUCTIBLE				
Per Admission	None	None	$250	$250
MAXIMUM CALENDAR YEAR COPAY				
Individual	$3,000	None	$2,000	None
Family	$6,000	None	$4,000	None
LIFETIME MAXIMUM BENEFIT				
	$2,000,000 *(per individual)*		None	
HOSPITAL				
Hospital - Inpatient and Outpatient *$250 deductible per admission for PERSCare inpatient*	20%	40%	10%	40%
PHYSICIAN SERVICES				
Office Visits	$20 copay [4]	40%	$20 copay [4]	40%
Hospital Outpatient	20% [4]	40%	10% [4]	40%
Other Professional Services	20% [4]	40%	10% [4]	40%
Preventive Care Services *(Services received for prevention and early detection of illness, including immunizations and period health exams)*	No charge [4]	40%	No charge [4]	40%
DIAGNOSTIC X-RAY/LAB				
	20%	40%	10%	40%
DURABLE MEDICAL EQUIPMENT[5]				
(Pre-certification required)	20% *($3,000 per calendar year)*	40%	10%	40%
AMBULANCE SERVICES				
	20%	20%	20%	20%
EMERGENCY SERVICES				
($50 deductible per visit for covered ER charges – waived if admitted to hospital)	20%	20%	10%	10%

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PERS Choice & PERSCare PPO Basic Plans

Note: All footnotes are located on inside back cover.

BENEFITS	PERS Choice		PERSCare	
PRESCRIPTION DRUG BENEFITS Applies to PERS Choice and PERSCare	Generic	Preferred Brand	Non-Preferred Brand	
Retail Pharmacy* **PERS Choice** *(up to 30-day supply)* **PERSCare** *(up to 34-day supply)* * *Short-term use*	$5	$15	$45 *($30 if medical necessity approved)*	
Retail Pharmacy Maintenance Medications filled after 2nd Fill** **PERS Choice** ***(up to 30-day supply)*** **PERSCare** ***(up to 34-day supply)*** ** *A maintenance medication taken longer than 60 days for chronic conditions.*	$10	$25	$75 *($45 if medical necessity approved)*	
Mail Service Pharmacy ***A $1,000 maximum copayment per person per calendar year applies (up to 90-day supply for PERS Choice and PERSCare)***	$10	$25	$75 *($45 if medical necessity approved)*	
	PPO	**Non-PPO**	**PPO**	**Non-PPO**
MENTAL HEALTH *(includes mental health parity provisions)*				
Inpatient	20% *(up to 20 days per calendar year)*	40%	10% [6] *(up to 30 days per calendar year)*	40% [6]
Outpatient	20% *(up to 24 visits per calendar year for other than severe mental illness or serious emotional disturbance of a child)*	40%	10% *(up to 30 visits per calendar year for other than severe mental illness or serious emotional disturbance of a child)*	40%
SUBSTANCE ABUSE *($12,000 lifetime maximum for any combination of inpatient and outpatient benefits)*				
Inpatient	20% *(up to 20 days per calendar year)*	40%	10% [6] *(up to 15 days per calendar year)*	40% [6]
Outpatient	20% *(up to 24 visits per calendar year)*	40%	10% *(up to 30 visits per calendar year)*	40%
HOME HEALTH SERVICES *(Pre-certification required; custodial care not covered)*				
	20% *(up to $6,000 per calendar year)*	40%	10% *(up to 100 visits per calendar year)*	40%
SKILLED NURSING FACILITY CARE *(Pre-certification required)*				
	20% *(first 10 days)*	40%	10% *(first 10 days)*	40%
	30% *(next 90 days)*	40%	20% *(next 170 days)*	40%

PERS Choice & PERSCare PPO Basic Plans

Note: All footnotes are located on inside back cover.

BENEFITS	PERS Choice		PERSCare	
SPEECH/PHYSICAL/OCCUPATIONAL THERAPY				
Speech Therapy *($5,000 lifetime maximum)*	20%	40%	10%	40%
Physical Therapy	20%	40%	10%	40%
Occupational Therapy	20%	20%	20%	20%
	(combined benefit maximum of $3,500 per calendar year for physical and occupational therapy)			
HOSPICE				
($10,000 lifetime maximum)	20%	20%	10%	10%
CHIROPRACTIC/ACUPUNCTURE				
(combined benefit for Chiropractic/Acupuncture)	20% *(15 visits per calendar year)*	40%	10% *(20 visits per calendar year)*	40%
BLOOD AND BLOOD PRODUCTS				
	20%	20%	20%	20%
HEARING AID SERVICES				
($1,000 maximum in 36-month period for hearing aids)	20%	40%	10%	40%

HMO Medicare Plans

Supplement to Original Medicare and Medicare Managed Care

Note: All footnotes are located on inside back cover.

	Supplement to Original Medicare Plans	Medicare Managed Care Plan (Medicare Advantage)
	Blue Shield of California [1] Western Health Advantage	Kaiser Permanente Senior Advantage
BENEFITS	**Copay and/or Benefit Limits**	**Copay and/or Benefit Limits**
HOSPITAL		
Inpatient	No charge	No charge
Outpatient	No charge	$10/visit
PHYSICIAN SERVICES		
Office Visits	$10/visit	$10/visit
Gynecological Exam	$10/visit	$10/visit
Periodic Health Exam	$10/visit	$10/visit
Allergy Testing/Treatment	$10/visit	$15/visit
Immunization/Inoculation	$10/immunization	$10/immunization
Vision Exam (Refraction)	$10 in network	$10/visit
Hearing Exam/Screening	$10/visit	$10/visit
Inpatient Hospital Visits	No charge	No charge
Surgery/Anesthesia	No charge	$10/visit
DIAGNOSTIC X-RAY/LAB		
Outpatient Services	No charge	No charge
PRESCRIPTION DRUGS		
Retail Pharmacy *(up to 30-day supply)* *(Does not apply to Kaiser.)*	$5/generic $15/formulary brand name $45/non-formulary brand name *($30 if medical necessity approved)*	$5/generic $15/brand name *Kaiser Permanente provides up to 100-day supply (or a 30-day supply for certain drugs) through its pharmacies or mail order program.*
Mail Order Program *$1,000 maximum copayment per person per calendar year. (up to 90-day supply)* *(Does not apply to Kaiser.)*	$10/generic $25/formulary brand name $75/non-formulary brand name *($45 if medical necessity approved)*	$5/generic $15/brand name *Kaiser Permanente provides up to 100-day supply (or a 30-day supply for certain drugs) through its pharmacies or mail order program.*
DURABLE MEDICAL EQUIPMENT		
	No charge	No charge
AMBULANCE		
Air/ground ambulance services	No charge	No charge

HMO Medicare Plans

Supplement to Original Medicare and Medicare Managed Care

Note: All footnotes are located on inside back cover.

	Supplement to Original Medicare Plans	Medicare Managed Care Plan (Medicare Advantage)
	Blue Shield of California [1] Western Health Advantage	Kaiser Permanente Senior Advantage
BENEFITS	**Copay and/or Benefit Limits**	**Copay and/or Benefit Limits**
EMERGENCY SERVICES		
Waived if hospitalized as an inpatient or for observation as an outpatient	$50/visit	$50/visit
MENTAL HEALTH		
Inpatient	No charge; certain limits apply. Refer to EOC	No charge; up to 45 days/year after Medicare's 190 lifetime days are exhausted. *(Limits not applied to certain conditions; see EOC.)*
Outpatient	$10 - $20/visit; refer to EOC	$10/visit
SUBSTANCE ABUSE TREATMENT		
Inpatient *Acute medical detoxification only*	No charge	No charge
Outpatient	$10/visit; up to 20 visits/calendar year	$10/visit; up to 20 visits/calendar year
HOME HEALTH SERVICES		
Custodial care not covered	No charge	No charge
SKILLED NURSING FACILITY CARE		
Medically necessary services provided in licensed skilled nursing facility. Custodial care not covered.	No charge *(up to maximum /100 days per Medicare benefit period)*	No charge
SPEECH/PHYSICAL/OCCUPATIONAL THERAPY		
	$10/visit	$10/visit
HOSPICE		
	No charge	No charge
ACUPUNCTURE		
	Not covered	$10/visit ***(when deemed medically necessary by a physician)***
BIOFEEDBACK		
	No charge	No charge
CHIROPRACTIC		
Services covered by Medicare	$10/visit *Western Health Advantage allows 20 visits/year beyond Medicare benefit.*	$10/visit *Kaiser allows 20 visits/year beyond Medicare benefit. (only in California)*

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HMO Medicare Plans

Supplement to Original Medicare and Medicare Managed Care

Note: All footnotes are located on inside back cover.

	Supplement to Original Medicare Plans	**Medicare Managed Care Plan (Medicare Advantage)**
	Blue Shield of California [1] Western Health Advantage	Kaiser Permanente Senior Advantage
BENEFITS	**Copay and/or Benefit Limits**	**Copay and/or Benefit Limits**
BLOOD & BLOOD PRODUCTS		
	No charge	No charge
HEARING AID SERVICES		
Audiological Exam	No charge	No charge *(Covered only in California)*
Hearing Aids	$1,000 maximum *(every 36 months)*	$1,000 maximum *(every 36 months)* *(Covered only in California)*

PERS Choice & PERSCare Supplement Plans

PPO Supplement to Original Medicare Plans

Note: All footnotes are located on inside back cover.

BENEFITS	PERS Choice	PERSCare
CALENDAR YEAR DEDUCTIBLE		
	None Plan pays Medicare Parts A and B deductible	None Plan pays Medicare Parts A and B deductible
LIFETIME MAXIMUM BENEFIT		
	$2,000,000 per individual *(after Medicare payments)*	None
HOSPITAL BENEFITS		
Hospital—Inpatient and Outpatient	No charge [7]	No charge [7] [8]
PHYSICIAN SERVICES		
Physician Office Visits	No charge [7]	No charge [7]
Home Visits	No charge [7]	No charge [7]
Hospital Visits	No charge [7]	No charge [7]
Gynecological Exam	No charge [7]	No charge [7]
Allergy Testing/Treatment	No charge [7]	No charge [7]
DIAGNOSTIC X-RAY/LAB		
	No charge [7]	No charge [7]
DURABLE MEDICAL EQUIPMENT		
	No charge [7]	No charge [7]
AMBULANCE		
	No charge [7]	No charge [7]
EMERGENCY SERVICES		
	No charge [7]	No charge [7]

PRESCRIPTION DRUG BENEFITS [8] Applies to PERS Choice and PERSCare	Generic	Preferred Brand	Non-Preferred Brand
Retail Pharmacy* ***PERS Choice*** *(up to 30-day supply)* ***PERSCare*** *(up to 34-day supply)* ** Short-term use*	$5	$15	$45 *($30 if medical necessity approved)*
Retail Pharmacy Maintenance Medications filled after 2nd Fill** ***PERS Choice (up to 30-day supply)*** ***PERSCare (up to 34-day supply)*** *** A maintenance medication taken longer than 60 days for chronic conditions.*	$10	$25	$75 *($45 if medical necessity approved)*
Mail Service Pharmacy ***A $1,000 maximum copayment per person per calendar year applies (up to 90-day supply for PERS Choice and PERSCare)***	$10	$25	$75 *($45 if medical necessity approved)*

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PERS Choice & PERSCare Supplement Plans

PPO Supplement to Original Medicare Plans

Note: All footnotes are located on inside back cover.

BENEFITS	PERS Choice	PERSCare
MENTAL HEALTH		
Inpatient	No charge [7]	No charge [7] [8]
Outpatient – *includes outpatient substance abuse (Medicare pays 50% of the approved amount for most services)*	Excess charges [7]	Excess charges [7] [8]
HOME HEALTH CARE		
	No charge [7]	No charge [7] [8]
SKILLED NURSING FACILITY		
Up to 100 days each benefit period in a Medicare approved facility	No charge [7]	No charge [7] [8]
From 101 to 365 days *(must be certifed by Blue Cross)*	Not covered	20% [7] [8]
SPEECH/PHYSICAL/OCCUPATIONAL THERAPY		
Speech Therapy	No charge [7]	No charge [7] [8] $5,000 lifetime benefit
Physical Therapy	No charge [7]	No charge [7] [8]
Occupational Therapy	No charge [7]	No charge [7] [8]
HOSPICE		
	No charge [7]	No charge [7]
ACUPUNCTURE		
	Not covered	20% [8]
BIOFEEDBACK		
	No charge [7]	No charge [7]
CHIROPRACTIC		
	No charge [7]	No charge [7]
BLOOD AND BLOOD PRODUCTS		
	No charge [7] ***(all but first three pints per calendar year)***	20% [8]
DIABETES SERVICES		
(includes diabetes self management, training, glucose monitors, test strips, lancets, etc.)	No charge [7]	No charge [7]
HEART TRANSPLANTS		
	No charge [7]	No charge [7]
KIDNEY DIALYSIS AND TRANSPLANTS		
	No charge [7]	No charge [7]

PERS Choice & PERSCare Supplement Plans

PPO Supplement to Original Medicare Plans

Note: All footnotes are located on inside back cover.

BENEFITS	PERS Choice	PERSCare
PODIATRIST SERVICES		
	No charge [7]	No charge [7]
CHRISTIAN SCIENCE TREATMENT		
Treatment of services by a Christian Science practitioner, nurse or hospital	No charge [7]	No charge [7]
HEARING AID SERVICES		
	20% [8 9] *(maximum payment of $1,000 once every 36 months)*	20% [9 10] *(maximum payment of $2,000 once every 24 months)*
VISION CARE		
One exam and two lenses per calendar year; one set of frames during a 24-month period Maximum Allowances: *Exam $35; Frames $30* *Each Lens: Single Vision $20, Bifocal $35, Trifocal $45, Lenticular $50, Contact Lenses $100* *Vision Service Plan (VSP) for California Residents*	Any amount in excess of the maximum allowance [8]	Any amount in excess of the maximum allowance [8]
BENEFITS BEYOND MEDICARE		
Hearing Aid Services	Yes [8 10]	Yes [8 9]
Vision Care	Yes [8]	Yes [8]
Prescription Drugs	Yes [8]	Yes [8]
Skilled Nursing Facility	No	Yes [8]
Acupuncture	No	Yes [8]
Physical Therapy	No	Yes [8]
Speech Therapy	No	Yes [8]
Occupational Therapy	No	Yes [8]
Mental Health Services	No	Yes [8]

CCPOA Association Plans (HMO)

Basic Plan – Regions North [11] and South [12]

Note: All footnotes are located on inside back cover.

BENEFITS	HMO Copay/Limits [13]
HOSPITAL	
Inpatient	No charge Not covered Access + [13]
Outpatient Facility Services	No charge Not covered Access + [13]
Outpatient Surgery	$50/visit Not covered Access + [13]
PHYSICIAN SERVICES	
Office Visits	$10/visit $10/visit Access + [13]
Gynecological Exam	$10/visit $10/visit Access + [13]
Periodic Health Exam	$10/visit
Well-Baby Care	$10/visit $10/visit Access + [13]
Allergy Testing/Treatment	$10/visit
Immunization/Inoculation	No charge
Vision Exam (Refraction)	$10/visit
Hearing Exam/Screening	$10/visit $10/visit Access + [13]
Inpatient Hospital Visits	No charge Not covered Access + [13]
Surgery/Anesthesia	No charge Not covered Access + [13]
DIAGNOSTIC X-RAY/LAB	
	No charge No charge Access + [13]
PRESCRIPTION DRUGS	
Deductible	Calendar year prescription deductible $50/per member; $150/per family
Retail Pharmacy *(up to 30-day supply)*	$10/generic $25/formulary brand name $50/non-formulary
Mail Order Program *(90-day supply)*	$20/generic $50/formulary brand name $100/non-formulary

CCPOA Association Plans (HMO)

Basic Plan – Regions North [11] and South [12]

Note: All footnotes are located on inside back cover.

BENEFITS	HMO Copay/Limits [13]
DURABLE MEDICAL EQUIPMENT	
	No charge Not covered Access + [13]
INFERTILITY TESTING/TREATMENT	
	50% of allowed charges Not covered Access + [13]
AMBULANCE	
	No charge
EMERGENCY SERVICES	
	$75/visit; waived if admitted
MENTAL HEALTH	
Inpatient *(Severe mental illness or serious emotional disturbance of a child)*	No charge Not covered Access + [13]
Outpatient *(Severe mental illness or serious emotional disturbance of a child)*	$10/visit
(Conditions that do not meet severe or serious criteria)	$20/visit (20 visits/year) Not covered Access + [13]
SUBSTANCE ABUSE TREATMENT	
Inpatient	No charge *(30 days/year)* Not covered Access + [13]
Outpatient	$10/visit *(20 visits/year)* Not covered Access + [13]
HOME HEALTH SERVICES	
	$10/visit Not covered Access + [13]
SKILLED NURSING FACILITY CARE	
	No charge *(up to 100 days/year)* Not covered Access + [13]
SPEECH/PHYSICAL/OCCUPATIONAL THERAPY	
	No charge
HOSPICE	
	No charge Not covered Access + [13]

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CCPOA Association Plans (HMO)

Basic Plan – Regions North [11] and South [12]

Note: All footnotes are located on inside back cover.

BENEFITS	HMO Copay/Limits [13]
ACUPUNCTURE	
	Not covered
BIOFEEDBACK	
	$10/visit
CHIROPRACTIC	
	$10/visit *(20 visits/year maximum)* Not covered Access + [13]
BLOOD & BLOOD PRODUCTS	
	No charge
HEARING AID SERVICES	
Audiological Evaluation	$10/visit
Hearing Aid	$500 maximum per calendar year toward one or more hearing aids and ancillary equipment Not covered Access + [13]
FAMILY PLANNING SERVICES	
Injectable Contraceptives *(including, but not limited to, Depo Provera)*	No charge
Sterilization for males or females	$10 charge
PREGNANCY & MATERNITY CARE	
Prenatal & Postnatal Initial Exam	$10/visit

CCPOA Association Plans (HMO)

Medicare Plan Supplement to Original Medicare – Regions: North [11] and South [12]

Note: All footnotes are located on inside back cover.

BENEFITS	HMO Copay/Limits
HOSPITAL	
Inpatient	No charge
Outpatient Surgery	No charge
PHYSICIAN SERVICES	
Office Visits	$5/visit
Gynecological Exam	No charge
Periodic Health Exam	No charge
Allergy Testing/Treatment	$10/visit
Immunization/Inoculation	No charge
Vision Exam (Refraction)	$5/visit
Hearing Exam/Screening	No charge
Inpatient Hospital Visits	No charge
Surgery/Anesthesia	No charge
DIAGNOSTIC X-RAY/LAB	
	No charge
PRESCRIPTION DRUGS	
Retail Program *(up to 30-day supply)*	$5/generic $20/formulary brand name $35/non-formulary
Mail Order Program *(90-day supply)*	$10/generic $40/formulary brand name $70/non-formulary
DURABLE MEDICAL EQUIPMENT	
	No charge
AMBULANCE	
	No charge
EMERGENCY SERVICES	
	No charge
MENTAL HEALTH	
Inpatient *(Severe mental illness or serious emotional disturbance of a child)*	No charge
Outpatient *(Severe mental illness or serious emotional disturbance of a child)*	No charge
(Conditions that do not meet severe or serious criteria)	$5/visit *(20 visits/year)*

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CCPOA Association Plans (HMO)

Medicare Plan Supplement to Original Medicare – Regions: North [11] and South [12]

Note: All footnotes are located on inside back cover.

BENEFITS	HMO Copay/Limits
SUBSTANCE ABUSE TREATMENT	
Inpatient	No charge
Outpatient	$5/visit
HOME HEALTH SERVICES	
	No charge
SKILLED NURSING FACILITY CARE	
	No charge *(up to 100 days per Medicare benefit period)*
SPEECH/PHYSICAL/OCCUPATIONAL THERAPY	
	No charge
HOSPICE	
	No charge
ACUPUNCTURE	
	Not covered
BIOFEEDBACK	
	As covered by Medicare
CHIROPRACTIC	
	$10/visit *(up to 20 visits/year)*
BLOOD & BLOOD PRODUCTS	
	No charge
HEARING AID SERVICES	
Audiological Evaluation	No charge
Hearing Aids	$500 maximum per calendar year toward one or more hearing aids and ancillary equipment

CAHP & PORAC Association Plans (PPOs)

Basic Plans

Note: All footnotes are located on inside back cover.

BENEFITS	CAHP Copay/Limits		PORAC Copay/Limits	
	PPO	Non-PPO [14]	PPO	Non-PPO [14]
DEDUCTIBLES				
	None	None	$300/individual or $900/family	$600/individual or $1,800/family
OUT-OF POCKET MAXIMUM				
	$2,000/member $4,000/family	None	$3,000/individual or $6,000/family *(Combined PPO and non-PPO)*	$3,000/individual or $6,000/family *(Combined PPO and non-PPO)*
LIFETIME MAXIMUM				
	$2,000,000	$2,000,000	none	none
HOSPITAL				
Inpatient	10%	Varies. See EOC	10%	10% *(varies)*
Outpatient	10%	40%	10%	10% *(varies)*
PHYSICIAN SERVICES				
Office Visits	$15 *(waived for preventive care)*	40%	$20 *(deductible does not apply)*	10%
Gynecological Exam	Included in periodic health exam	Included in periodic health exam	Included in periodic health exam	Included in periodic health exam
Periodic Health Exam	No charge; $300/yr maximum; [15] Subscriber, spouse & dependents age 7+	No charge; $300/yr maximum; [15] Subscriber, spouse & dependents age 7+	No charge; $500/yr maximum; [15] Subscriber, spouse & dependents age 17+ *(includes electron beam tomography for subscriber only)*	No charge; $500/yr maximum; [15] Subscriber, spouse & dependents age 17+
Well-Child Care	No charge & unlimited visits under age 7	No charge & unlimited visits under age 7	No charge Age 6 and under/no limit Age 7 and older/$500 yr maximum	No charge Age 6 and under/no limit Age 7 and older/$500 yr maximum
Allergy Testing/Treatment	10%	40%	10%	10%
Immunization/Inoculation	10% *(Unless part of well-baby care or periodic health exam)*	40%	Included in well-baby/child care	Included in well-baby/child care
Vision Exam (Refraction)	Not covered	Not covered	Not covered	Not covered

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CAHP & PORAC Association Plans (PPOs)

Basic Plans

Note: All footnotes are located on inside back cover.

BENEFITS	CAHP Copay/Limits		PORAC Copay/Limits	
	PPO	Non-PPO [14]	PPO	Non-PPO [14]
PHYSICIAN SERVICES				
Hearing Exam/Screening	10%; $200/ maximum [15] *(per 36 months)*	40%; $200/ maximum [15] *(per 36 months)*	20%; maximum $50/exam with hearing aid purchase [15]	20%; maximum $50/exam with hearing aid purchase [15]
Inpatient Hospital Visits	10%	40%	10%	10% *(varies)*
Surgery/Anesthesia	10%	40%	10%	10% *(varies)*
DIAGNOSTIC X-RAY/LAB				
See all footnotes	10%	40%	10%	10% *(varies)*
PRESCRIPTION DRUGS				
Retail Pharmacy *CAHP (up to 30-day supply) PORAC (up to 34-day supply or 100 pills/units, whichever is more)*	$5/generic $20/single source $25/multi-source [17]	$5/generic $20/single source $25/multi-source	$10/generic $25/ formulary brand name $45/non-formulary brand name	Limited fee schedule
Retail Pharmacy Maintenance Medications filled after 2nd Fill** *CAHP (up to 30-day supply) ** A maintenance medication taken longer than 60 days for chronic conditions.*	$10/generic $40/single source $50/multi-source [17]	$10/generic $40/single source $50/multi-source [17]	Not applicable	Not applicable
Mail Order Program *CAHP (up to 90 day supply PORAC (up to 90 day supply or 100 pills/units, whichever is more)*	$10/generic $40/single source $50/multi-source [17]	$10/generic $40/single source $50/multi-source	$20/generic $45/formulary brand name $75/non-formulary brand name	Not applicable
DURABLE MEDICAL EQUIPMENT				
	10%	40%	20%	20%
INFERTILITY TESTING/TREATMENT				
	Not covered	Not covered	Limited benefits	Limited benefits
AMBULANCE				
	20%	20%	20%	20%
EMERGENCY SERVICES				
Emergency	$25 + 10%	$25 + 10%	10%	10% *(varies)*
Non-emergency	$25 + 10%	$25 + 40%	50%	50% *(varies)*

CAHP & PORAC Association Plans (PPOs)

Basic Plans

Note: All footnotes are located on inside back cover.

BENEFITS	CAHP Copay/Limits		PORAC Copay/Limits	
	PPO	Non-PPO [14]	PPO	Non-PPO [14]
MENTAL HEALTH				
Inpatient	See EOC	See EOC	See EOC	See EOC
Outpatient	See EOC	See EOC	See EOC	See EOC
SUBSTANCE ABUSE TREATMENT				
All covered services *(inpatient and outpatient)*	$30,000 lifetime maximum; $15,000 maximum/year	$30,000 lifetime maximum; $15,000 maximum/year	$30,000 lifetime maximum; $15,000 maximum/year	$30,000 lifetime maximum; $15,000 maximum/year
HOME HEALTH SERVICES				
	10% *(up to 90 visits/ period of disability [15] See EOC)*	40% *(up to 90 visits/ period of disability [15] See EOC)*	10%; 100 visits maximum/year combined PPO/ non-PPO	10%; 100 visits maximum/year combined PPO/ non-PPO
SKILLED NURSING FACILITY CARE				
	10% *(for up to 100 days/confinement) [15]*	40% *(for up to 100 days/confinement) [15]*	10% *(for up to 100 days/year) [15]*	10% *(for up to 100 days/year) [15]*
SPEECH/PHYSICAL/OCCUPATIONAL THERAPY				
Speech	10%	40%	10%	10%
Physical	10% *(pre certification required for more than 24 visits/year) [15]*	40% *(pre certification required for more than 24 visits/year) [15]*	$20/office visit *(no deductible);* 10% on all other charges; 20 visits/year	10% maximum coverage $35/visit $700/total services obtained *(physical and occupational combined)*
Occupational	10%	40%	$20/office visit *(no deductible);* 10% on all other charges; 20 visits/year	
HOSPICE				
	No charge *($7,500 lifetime maximum) [15]*	No charge *($7,500 lifetime maximum) [15]*	10%	10%

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CAHP & PORAC Association Plans (PPOs)

Basic Plans

Note: All footnotes are located on inside back cover.

BENEFITS	CAHP Copay/Limits		PORAC Copay/Limits	
	PPO	Non-PPO [14]	PPO	Non-PPO [14]
ACUPUNCTURE				
	10%; 20 visits/ year combined chiropractic and acupuncture [15]	40%; 20 visits/ year combined chiropractic and acupuncture [15]	10%	10%
CHIROPRACTIC				
	See Acupuncture	See Acupuncture	Maximum combined with Physical & Occupational Therapy	Maximum combined with Physical & Occupational Therapy
BLOOD & BLOOD PRODUCTS				
	20%	20%	20%	20%
HEARING AID SERVICES				
	10%; $1,000 maximum/36 months [15]	40%; $1,000 maximum/36 months [15]	20%; $450 per ear maximum/36 months [15]	20%; $450 per ear maximum/36 months [15]

CAHP & PORAC Association Plans (PPOs)

PPO Supplement to Original Medicare

Note: All footnotes are located on inside back cover.

BENEFITS	CAHP Copays/Limits [16]	PORAC Copays/Limits [16]
DEDUCTIBLES		
	$100/individual $200/family *(Major Medical deductible)*	$100/individual $200/family *(Major Medical deductible)*
HOSPITAL		
Inpatient	No charge	No charge. Plan pays after Medicare benefits are exhausted. See EOC
Outpatient	No charge	No charge
PHYSICIAN SERVICES		
Office Visits	$10/visit	No charge
Gynecological Exam	No charge	No charge
Periodic Health Exam	Not covered unless Medicare approved	Not covered unless Medicare approved
Allergy Testing/Treatment	No charge	No charge
Immunization/Inoculation	No charge	No charge
Vision Exam (Refraction)	Not covered	20%; $40 maximum frames and lens combined
Hearing Exam/Screening	No charge	20%; $50/exam in connection with hearing aid purchase
Inpatient Hospital Visits	No charge	No charge
Surgery/Anesthesia	No charge	No charge
DIAGNOSTIC X-RAY/LAB		
	No charge	No charge
PRESCRIPTION DRUGS		
Retail Pharmacy *(up to 30-day supply)* *CAHP: Diabetic supplies paid under medical benefit.* *PORAC: $50 deductible/member for retail only*	$5/generic $20/single source $25/multi-source [17]	**PPO Provider:** $10/generic $25/formulary brand name $45/non-formulary brand name **Non-PPO:** Limited to strict fee schedule.
Retail Pharmacy Maintenance Medications filled after 2nd fill** ***CAHP (up to 30-day supply)*** *** A maintenance medication taken longer than 60 days for chronic conditions.*	10/generic $40/single source $50/multi-source [17]	Not applicable
Mail Order Program *(90-day supply)*	$10/generic $40/single source $50/multi-source [17]	$20/generic $45/formulary brand name $75/non-formulary brand name

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CAHP & PORAC Association Plans (PPOs)

PPO Supplement to Original Medicare

Note: All footnotes are located on inside back cover.

BENEFITS	CAHP Copays/Limits [16]	PORAC Copays/Limits [16]
DURABLE MEDICAL EQUIPMENT		
	No charge	No charge
AMBULANCE		
	No charge	No charge
EMERGENCY SERVICES		
	No charge	No charge
MENTAL HEALTH		
Inpatient	No charge	No charge
Outpatient	See EOC	No charge; 50% Major Medical limited benefits. See EOC
SUBSTANCE ABUSE TREATMENT		
Inpatient	Not covered unless Medicare approved	Not covered unless Medicare approved
Outpatient	Not covered unless Medicare approved	Not covered unless Medicare approved
HOME HEALTH SERVICES		
	No charge	No charge
SKILLED NURSING FACILITY CARE		
	No charge; 20% after Medicare benefits exhausted	No charge; plan pays after Medicare benefits exhausted See EOC
SPEECH/PHYSICAL/OCCUPATIONAL THERAPY		
	No charge; Speech: $5,000 lifetime maximum	No charge
HOSPICE		
	No charge; $7,500 lifetime maximum	No charge
ACUPUNCTURE		
	No charge; 20% if not Medicare approved	20% Major Medical benefits
BIOFEEDBACK		
	No charge; 20% if not Medicare approved	See EOC

CAHP & PORAC Association Plans (PPOs)

PPO Supplement to Original Medicare

Note: All footnotes are located on inside back cover.

BENEFITS	CAHP Copays/Limits [16]	PORAC Copays/Limits [16]
CHIROPRACTIC		
	No charge; 20% if not Medicare approved	No charge; 20% Major Medical benefits. See EOC
BLOOD & BLOOD PRODUCTS		
	20% first three units payable under Major Medical benefits	No charge first three units; 20% Major Medical benefits
HEARING AID SERVICES		
Audiological Exam	10% if not Medicare approved; $200 maximum *(per 36 months)*	20%; $50/exam in connection with hearing aid purchase
Hearing Aids	10%; $1,000 maximum *(per 36 months)*	20%; $450 per ear *(per 36 months)*
HEALTH EDUCATION CLASSES		
	No charge if Medicare approved	Not covered if Medicare approved

Footnotes

1 The Blue Shield Exclusive Provider Organization (EPO) Plan **only serves Colusa, Lake, Mendocino, Plumas, Sierra and parts of El Dorado counties.** The plan offers the same covered services as the Blue Shield Access + HMO plan, but members must seek services from Blue Shield's statewide PPO network of preferred providers. Members are not required to select a personal physician.

2 All charges indicated are for in-network providers.

3 The maximum plan year copayment applies when: (1) covered services are received from a Preferred Provider or (2) if you live and receive covered services OUTSIDE a Preferred Provider area. If you live WITHIN a Preferred Provider area, covered services received from Non-Preferred Providers, even if referred by a Preferred Provider, do NOT apply toward the maximum calendar year copayment.

4 These services are NOT subject to the calendar year deductible if received from a Preferred Provider.

5 Pre-certification required for durable medical equipment priced at $1,000 or more for PERSCare. A $3,000 calendar year maximum for durable medical equipment applies for PERS Choice.

6 A $250 hospital admission deductible applies for each admission for PERSCare.

7 If benefits are payable by Medicare and you use a provider who accepts Medicare assignment, covered services will be paid in full.

8 This is a benefit beyond Medicare. Refer to the EOC booklet for explanation.

9 PERSCare pays 80% of Blue Cross of California's Allowable Amount for hearing aid services, subject to a maximum payment of $2,000 per member once every 24 months.

10 PERS Choice pays 80% of Blue Cross of California's Allowable Amount for hearing aid services, subject to a maximum payment of $1,000 per member once every 36 months.

11 The northern region includes these counties: Alameda, Butte, Contra Costa, El Dorado +, Fresno +, Glenn, Kings, Madera, Marin, Mariposa, Merced, Napa, Nevada +, Placer +, Sacramento, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare & Yolo.

+ *Partial coverage.*

12 The southern region includes these counties: Imperial, Kern +, Los Angeles, Orange, Riverside +, San Bernardino +, San Diego, San Luis Obispo, Santa Barbara, & Ventura +.

+ *Partial coverage.*

13 Access + Specialist. You may arrange an office visit with a plan specialist in the same medical group or Independent Practice Association (IPA) as your PCP without a referral from your PCP.

14 Additional restrictions and limitations may apply to services obtained from a non-PPO provider. See EOC.

15 Limits apply to combined total of services obtained from PPO and non-PPO providers.

16 Additional fees may apply if services are not Medicare approved or are obtained from a doctor who does not accept Medicare assignment.

17 For CAHP, the third tier copayments of $25/retail and $50/mail will still apply when a physician writes "dispense as written" on the prescription. The member must **also** pay the difference between the cost of the multi-source brand and its generic equivalent.

CALIFORNIA PUBLIC EMPLOYEES' RETIREMENT SYSTEM

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